Released 7/2/99.

NO. OF ATTACHED SHEETS:

MEDICAL RECORD	REPORT OF MEDICAL HISTORY	DATE OF EXAM - *Today's Date*

NOTE: This information is for official and medically-confidential use only and will not be released to unauthorized persons

1. NAME OF PATIENT *(Last, first, middle)*	2. IDENTIFICATION NUMBER **SS#**	3. GRADE - *Level of Educ. Completed*
4a.. HOME STREEET ADDRESS *(Street or RFD; City or Town; State; and ZIP Code)*	5. EXAMINING FACILITY **NOT APPLICABLE**	
4b. CITY / 4c. STATE / 4d. ZIP CODE		

6. PURPOSE OF EXAMINATION

NOT APPLICABLE

7. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Use additional pages if necessary)*

a. PRESENT HEALTH	b. CURRENT MEDICATION	REGULAR OR INTERM.
c. ALLERGIES *(Include insect bites/stings and common foods)*		
	d. HEIGHT	e. WEIGHT
8. PATIENT'S OCCUPATION **Summer Student**	9. ARE YOU *(Check one)* ☐ RIGHT HANDED ☐ LEFT HANDED	

10. PAST/CURRENT MEDICAL HISTORY

CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW
Household contact with anyone with tuberculosis				Shortness of breath				Bone, joint or other deformity			
				Pain or pressure in chest				Loss of finger or toe			
Tuberculosis or positive TB test				Chronic cough				Painful or "trick" shoulder or elbow			
Blood in sputum or when coughing				Palpitation or pounding heart							
				Heart trouble				Recurrent back pain or any back injury			
Excessive bleeding after injury or dental work				High or low blood pressure							
				Cramps in your legs				"Trick" or locked knee			
Suicide attempt or plans				Frequent indigestion				Foot trouble			
Sleepwalking				Stomach, liver, or intestinal trouble				Nerve Injury			
Wear corrective lenses				Gall bladder trouble or gallstones				Paralysis *(including infantile)*			
Eye surgery to correct vision								Epilepsy or seizure			
Lack vision in either eye				Jaundice or hepatitis				Car, train, sea or air sickness			
Wear a hearing aid				Broken bones				Frequent trouble sleeping			
Stutter or stammer				Adverse reaction to medication				Depression of excessive worry			
Wear a brace or back support				Skin diseases				Loss of memory or amnesia			
Scarlet fever				Tumor, growth, cyst, cancer				Nervous trouble of any sort			
Rheumatic fever				Hernia				Periods of unconsciousness			
Swollen or painful joints				Hemorrhoids or rectal disease				Parent/sibling with diabetes, cancer, stroke or heart disease			
Frequent or severe headaches				Frequent or painful urination							
Dizziness or fainting spells				Bed wetting since age 12				X-ray or other radiation therapy			
Eye trouble				Kidney stone or blood in urine				Chemotherapy			
Hearing loss				Sugar or albumin in urine				Asbestos or toxic chemical exposure			
Recurrent ear infections				Sexually transmitted diseases							
Chronic or frequent colds				Recent gain or loss of weight				Plate, pin or rod in any bone			
Severe tooth or gum trouble				Eating disorder (anorexia bulimia, etc.)				Easy fatiguability			
Sinusitis								Been told to cut down or criticized for alcohol use			
Hay Fever or allergic rhinitis				Arthritis, Rheumatism, or Bursitis							
Head Injury								Used illegal substances			
Asthma				Thyroid trouble or goiter				Used tobacco			

11. FEMALES ONLY

CHECK EACH ITEM	YES	NO	DON'T KNOW	DATE OF LAST MENSTRUAL PERIOD	DATE OF LAST PAP SMEAR	DATE OF LAST MAMMO-GRAM
Treated for female disorder						
Change in menstrual pattern						

CHECK EACH ITEM. IF "YES" EXPLAIN IN BLANK SPACE TO RIGHT. LIST EXPLANATION BY ITEM NUMBER.

ITEM	YES	NO
12. Have you been refused employment or been unable to hold a job or stay in school because of.		
a. Sensitivity to chemicals, dust, sunlight, etc.		
b. Inability to perform certain motions.		
c. Inability to assume certain positions.		
d. Other medical reasons *(If yes, give reasons.)*		
13. Have you ever been treated for a mental condition? *(If yes, specify when, where, and give details.)*		
14. Have you ever been denied life insurance? *(If yes, state reason and give details.)*		
15. Have you had, or have you been advised to have, any operation? *(If yes, describe and give age at which occurred.)*		
16. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*		
17. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*		
18. Have you ever been rejected for military service because of physical, mental or other reasons? (I*f yes, give date and reason for rejection.)*		
19. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)*		
20. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? *(If yes, specify what kind, granted by whom, and what amount, when, why.)*		
21. Have you ever been arrested or convicted of a crime, other than minor traffic violations. *(If yes, provide details.)*		
22. Have you ever been diagnosed with a learning disability? *(If yes, give type, where, and how diagnosed.)*		

23. LIST ALL IMMUNIZATIONS RECEIVED

**** SUBMIT IMMUNIZATION RECORDS AS INSTRUCTED IN YOUR PRE-EMPLOYMENT LETTER ****

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

24a. TYPED OR PRINTED NAME OF EXAMINEE	24b. SIGNATURE	24c. DATE
TYPE OR PRINT YOUR NAME HERE		

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY".

25. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician shall comment on all positive answers in Items 7 through 11. Physician may develop by interview any additional medical history deemed important, and record any significant findings here.)*

NOT APPLICABLE

26a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	26b. SIGNATURE	26c. DATE
NOT APPLICABLE	**NOT APPLICABLE**	